MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11587
Do not use this space.

1. PLACE OF DEATH
(a) County Linn Registration District No. 1499
(b) Township Clay 2 Primary Registration District No. 15664 Registered No. 1
(c) City Meadville (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Elizabeth Anne Rosier
(a) Residence, No. S St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 16 1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	82	9	11	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. housekeeper
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Hagerstown
(STATE OR COUNTRY) Maryland

FATHER
13. NAME John Rosier
14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Maryland

MOTHER
15. MAIDEN NAME — Slade
16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Maryland

17. INFORMANT Nettie Hamilton
(ADDRESS) Meadville Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Meadville DATE Jan 29 1940

19. FUNERAL DIRECTOR Smiley Funeral Home
(ADDRESS) Wheeling Mo.

20. FILED 2/5/40 Geo. H. Clarkson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan-27 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan-23 1940 to Jan-27 1940
I last saw her alive on Jan-26 1940 Death is said to have occurred on the date stated above, at 1:45 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocardial degeneration	
Chronic Myocarditis	

Other contributory causes of importance: AJC

Name of operation Date of
What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Ed Weir, M. D.
(Address) Meadville Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
1 X12004

RECEIVED
District Health Officer No. 11
District File Number 4-40-454
Date Filed APR 9 1940

STATEMENT BY LICENSED EMBALMER

I, Frank L. Smiley, Licensed Embalmer No. 470

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Frank L. Smiley

L. E. .....

No. ..... or by ....., Registered Apprentice No. .....

working under my personal supervision.

Signed Frank L. Smiley

Licensed Embalmer No. 470

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

No. 2B
—2-21-40
T X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11587

Registration District No. 499

Primary Registration District No. 3664

Registrar's No.

1. PLACE OF DEATH
(a) County Clay
(b) ~~City or town~~ Liberty
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3. (a) PRINT FULL NAME Elizabeth Ann Rosser
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased Apr - 16 - 1858
(Month) (Day) (Year)

8. AGE: Years 81 ~~82~~ Months 9 Days 11 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
FATHER 13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
MOTHER 15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to 5/3/40 Gunshot Coarctation	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature E. S. Swezy (M. D. or other)
Address Meadville Mo Date signed

SUPPLEMENTARY

11587 (1940)